REPORT TO THE TWENTY-THIRD LEGISLATURE
STATE OF HAWAII
2006

PURSUANT TO ACT 178, SECTION 25,
SESSION LAWS OF HAWAII 2005, REQUIRING THE
DEPARTMENT OF HEALTH TO PREPARE A YEARLY
DETAILED PROGRESS REPORT ON THE STATUS OF
THE HEALTHY HAWAII INITIATIVE.

Prepared by:
State of Hawaii
Department of Health
Tobacco Settlement Special Fund
The Healthy Hawaii Initiative
October 2005

STATE OF HAWAII
DEPARTMENT OF HEALTH
REPORT TO THE 2006 LEGISLATURE
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A Brief Overview of the Healthy Hawaii Initiative

Using tobacco settlement funds, the Department of Health (DOH) created the Healthy Hawaii Initiative (HHI) to prevent and reduce the personal and societal burden of chronic diseases, such as diabetes, heart disease, and cancer. HHI uses a socio-ecological approach targeting the three major risk-associated behaviors that contribute to chronic disease: tobacco use, poor nutrition, and physical inactivity.

The HHI model is adapted from the Centers for Disease Control and Prevention's (CDC) best practices approach to comprehensive tobacco prevention and control. The four interrelated components of HHI are (I) coordinated school-based health, (II) community-based initiatives, (III) public and professional education, and (IV) surveillance, assessment, evaluation, and research. Most recently, an independent evaluator reviewed the HHI strategies and accomplishments to provide guidance on moving forward (see attachment 1). Measurable objectives were then updated by the major health risk areas and components in HHI to increase awareness and change behaviors of people in Hawaii around the three risk behaviors of nutrition, physical activity and tobacco (see attachment 2).

The DOH receives a net 25% of the Tobacco Settlement Special Fund for health promotion and prevention-oriented health programs. In fiscal year 2005, that amount was $8.9 million, of which Healthy Start received $4.7 million. Beginning in calendar year 2004, the Master Settlement Agreement payment is received in an installment in the last quarter of the state fiscal year. The actual payments have been 12% to 18% below projections. The project must maintain the department's sub-account or share of the total payment to roll over into the next fiscal year in order to operate the first nine months of the fiscal year. The combined impact of the reduction in the HHI budget and revenue payment schedule resulted in funding cuts across the strategic component areas. Components hardest hit were community-based initiatives down about 64% and public and professional education (cut by 38% and 100%, respectively). School-based health initiatives were reduced about 30 percent. With the reinstatement of the monies, HHI in fiscal year 2006 is moving forward to address the concerns of childhood and adult overweight and obesity, and tobacco prevention and cessation.

This report contains a synopsis of the accomplishments of the Healthy Hawaii Initiative from January to December 2005. Also included are projected activities for the remainder of fiscal year 2006, and the effect of the reallocation of funds from Healthy Start to HHI.

I. Coordinated School-based Health

Schools have been identified as the most important institution with the ability to improve educational and health outcomes for young people. Therefore, HHI has formed a partnership with the Department of Education (DOE), the University of Hawaii (UH), and external partners to form the Coordinated School Health Interagency Collaborative. This is a group that has used its partnerships to make large strides in changing school systems to increase students' physical and educational access to physical activity and nutrition information.

Funding for fiscal years 2004 and 2005 to the DOE was cut significantly, from $1.85 million to $1.05 million, due to the reallocation of HHI funding. The funding cuts resulted in the reduction of school-based interventions along the eight components of the Coordinated School Health Program (CSHP). Where the memorandum of agreement had previously supported up to 17 school and complex level CSHP coordinators, only one and one half positions were maintained in 2003-04. The positions were completely phased out in 2004-05. Funding for the UH College of

Education, Outreach College Summer Institute graduate courses was extended for $107,000 to support the training of teachers. The funding cuts provided an opportunity to go over the programmatic evaluations and to adjust strategies to build sustainability in schools to establish and maintain healthy learning environments.

Hawaii's Coordinated School Health Program (CSHP)

- In partnership with DOE, six school health teams were trained to implement Coordinated School Health at their schools. This pilot project will provide the information to develop a tool kit for statewide implementation and is projected to rollout in spring 2006. The training and tool kit reflects the new framework for the implementation of CSHP that does not rely on individual coordinators, instead training and tools are provided to empower school teams to work on creating healthy schools.

- With HHI funding, DOE hosted more than 2,400 teacher professional development days focused on health and physical education for a total of 1,600 teachers and other health education professionals. The UH offered eight graduate-level teacher education courses to over 175 teachers. These trainings help assure that students learn the necessary skills to make better choices in all areas of life, from nutrition and exercise, to tobacco and drug use. Schools received recognition for enrolling as teams for professional development. Vice principals and principals also participated in conferences and workshops with their teachers. This is another strategy for creating systemic changes in health education and physical education by schools.

- The HHI Summer Institute system provided the venue to create additional partnerships with groups (e.g., Safe & Drug-Free Schools, Temporary Assistance to Needy Families) that now support health-related teacher education courses.

Hawaii Action for Healthy Kids

HHI founded and staffs Hawaii Action for Healthy Kids, which focuses on improving school nutrition and physical activity.

- Hawaii Action for Healthy Kids is coordinating the development of the Hawaii Wellness Policy, in partnership with the DOE Office of Hawaii Child Nutrition Programs, as required by the Child Nutrition and WIC Reauthorization Act of 2004. (The policy will be in place by July 2006.)

- Hawaii Action for Healthy Kids piloted Recess-Before-Lunch. Many students rush through lunch, so they can have more time for recess. By changing the school system and scheduling recess *before* lunch, students are guaranteed time for physical activity and don't feel pressured to eat quickly. The first pilot was conducted at Kaneohe Elementary School. The participating grades had more active recess time, less plate waste and there were fewer referrals for behavioral problems. Currently, a research project is underway to determine the impact and feasibility of implementing Recess-Before-Lunch in all Hawaii elementary schools.

- With the additional HHI funds there are now plans to expand the school health strategies to improve the school nutrition environment. Additional strategies such as the Healthy Hawaii School Challenge will recognize schools that are actively improving their nutrition and physical activity environments and provide an incentive for schools to exceed guidelines set forth in the Hawaii Wellness Policy (proposed Board of Education policy adoption date is July 2006). This expanded capacity will also provide mini-grants to assist schools in meeting their nutrition and physical activity goals, e.g. have physical education in every grade level through a coordinated approach to school health.

II. Community-based Initiatives

The Centers for Disease Control's (CDC) *Guide to Community Preventive Services* shows evidence and strongly recommends community-wide campaigns as an effective intervention for increasing physical activity and improving physical fitness. HHI is committed to community partnerships and supports targeted interventions for sustainable social and environmental

changes. Community involvement and ownership are critical to the overall sustainability and success of efforts.

Due to the funding reallocation, round two of the community intervention request for proposals was cancelled for the biennium fiscal years of 2004 and 2005. Community interventions that were extended are, Ke Kula ‘o Samuel Kamakau Laboratory Public Charter School, Friends for Fitness Coalition (West Hawaii), Kauai County, City and County of Honolulu Department of Parks and Recreation, University of Hawaii College of Tropical Agriculture and Human Resources, Walkable Communities and Safe Routes to School, and Kokua Kalihi Valley. In the previous biennium the combined community-based interventions budget was $1.95 million and the budget was reduced to $694,300 in fiscal year 2005.

In fiscal year 2006 the foundational work is the development of a comprehensive state nutrition and physical activity plan that will provide guidance for HHI and other stakeholders. The earlier community-based grant evaluations indicated the need to build capacity for understanding comprehensive and sustainable approaches to physical activity and nutrition. Also, the communities that continued beyond funding and excelled were those that showed the most readiness in the beginning for creating community norm changes. Therefore, as HHI moves forward resources are being targeted towards supporting the development of the state plan, to maintain successful community initiatives through FY06 so they can become self-sustaining, and to support community-driven coalitions.

Hawaii Physical Activity and Nutrition Statewide Plan

The Twenty-Third Legislature, Regular Session of 2005, passed Senate Concurrent Resolution No. 7, H.D. 1 (SCR7) requesting the DOH propose and develop a comprehensive statewide strategic plan to address the prevention and treatment of childhood obesity and healthy lifestyles.

- In October 2005, the HHI convened a diverse group of community representatives to design Hawaii’s Statewide Plan for Physical Activity and Nutrition: *Building Hawaii’s Capacity for Healthy Lifestyles*. As members of the planning committee, individuals and the organizations they represent have a vested interest in the plan and making its goals a reality.

- Comprehensive strategies, recommendations, policies, and action steps were identified that support and build environments that will make it easier for Hawaii residents to choose healthy foods and to be physically active. The plan will be unveiled in Spring 2006.

Statewide Physical Activity and Nutrition Coalition

Healthy Hawaii Initiative has set in progress the organization of advocates for physical activity and nutrition in order to build a coalition comprised of representatives from state agencies, universities, professional organizations, volunteer organizations, and community partners. These strategic partnerships will prove useful for focusing community efforts and accomplishing a broad range of goals that reach beyond the capacity of any individual member organization.

- The coalition’s mission is to build state-wide capacity for developing an environment to support and promote healthy food choices and lifelong physical activity through collaborated and coordinated communication.

- The coalition will serve as:
    1. Resource and advisory body for nutrition and physical activity.
    2. Facilitator of the implementation of the Hawaii Physical Activity and Nutrition Statewide Plan.

Neighbor Island County Coalitions

HHI will use some of the returned funds to establish and support Neighbor Island physical activity and nutrition coalitions. County coalitions will ensure local concerns and needs are addressed and that county-specific initiatives for physical activity and healthy eating are implemented. Maui will be funded for a county level coalition through a request for proposal process. Kaua`i and Hawaii will be pilots for a different model discussed below called the Hawaii Nutrition Network.

Hawaii Nutrition Network (HNN)

The United States Department of Agriculture's (USDA) Food Stamp Nutrition Education (FSNE) program provides eligible low-income households a means to access a healthy, nutritious diet. FSNE encourages and supports nutrition education designed to help food stamp participants choose healthy foods and active lifestyles.

- With the return of funds, HHI will participate in the FSNE program. This will also allow HHI to maximize federal reimbursements while increasing the reach to populations that most need the nutrition and physical activity education.

- Under FSNE, the USDA will reimburse states for 50% of the allowable administrative costs deemed reasonable and necessary to operate the FSNE activities.

- Some of the funding returned to HHI will be used to staff and implement the Hawaii Nutrition Network (HNN). Using a network of partner agencies, Hawaii will be able to obtain a 100% match on funds expended through HNN on nutrition education. Partners in this effort can include public, private, and faith organizations.

- The first pilots of the HNNs at the community level will be in Kaua`i and Hawaii counties through the District Health Offices. Oahu (geographic area of City and County of Honolulu) will be included in the state partnership building process of the HNN.

Worksite Wellness Initiative

Hawaii's residents spend most of their hours at work and many feel they don't have time to be physically active everyday. The worksite environment has proven to have a powerful impact on individuals' health. Scientific research shows that a company's productivity is tied to employee health. Worksite health programs can improve productivity, recruitment and retention, and worksite morale.

- Department of Health Worksite Wellness campaign:

  - HHI is conducting a 10 week long participatory planning process with employees of the DOH to develop comprehensive strategies and recommendations for a healthy worksite.

  - In October 2005, HHI launched Stairwell to Health, a pilot program that promotes stairwell use in Kinau Hale. Stairwell enhancements include newly painted walls, framed artwork, music, and motivational signs that encourage physical activity. Infrared beam counters are being used to track the number of stair users.

- Tool kits for both public and private employers will be available in early 2006. The tool kit will provide resources for employers on how to plan, assess, and successfully implement physical activity and nutrition interventions at their worksite.

Ke Kula `o Samuel M. Kamakau Laboratory Public Charter School

Hawaiian immersion schools are unique educational environments for culturally appropriate interventions regarding healthy eating choices for students.

- With HHI funds, Kamakau was able to develop and implement a food-based curriculum that includes a participatory food service project for its students and made it available to other charter schools.

- HHI funded charter schools provide nutrition education to approximately 450 Hawaiian immersion students, their families, and 60 non-immersion students in eight schools on O`ahu, Hawaii, and Kaua`i.

- The consumption of fruits and vegetables of students involved in the HHI project surpasses all other groups surveyed in Hawaii, and the national average for high school students.

Friends for Fitness

Using HHI funds, Friends for Fitness, a group of community volunteers, mobilized their community to revitalize the old Kona Airport Park and enhance the Maka`eo Walking/Jogging Path. This created a safe place to walk in a community that was lacking adequate facilities. The sustained community interest in the park is leading more residents to be physically active.

- Walking counts over a three-day period in January 2005, showed 721 park users, up from 582 in January of 2003.

- Friends for Fitness organized and mobilized residents and community groups to provide on-going maintenance of the walking path and surrounding area. In addition to daily maintenance, at least 30 to 50 residents turn out each month for a workday for large scale path maintenance projects.

- Friends for Fitness engaged local businesses to embrace employee wellness by promoting physical activity through a fitness challenge. Fourteen teams of ten people representing local businesses walked a total of 4,476 miles for their health and raised funds to enhance Maka`eo Walking/Jogging Path.

City and County of Honolulu, Department of Parks and Recreation

With HHI funding, the Department of Parks and Recreation (DPR) is expanding opportunities for physical activity for the general population in urban Honolulu neighborhoods by teaming up with DOE's high schools.

- DPR and DOE co-drafted a model Joint-Use Agreement for the use of school facilities during non-school hours.

- DPR collaborated with Farrington High School in developing and implementing a recreational program focused on providing a range of physical activity classes in the Kalihi-Palama area.

- DPR engaged in non-traditional methods to encourage participation from this multi-ethnic population. With the assistance of the Farrington ESL staff, the DPR was able to distribute program schedules in Tagalog, Ilocano, Chuukese, and Samoan to social service agencies and health care providers in the area. Other DPR outreach activities included meeting with school clubs, faculty and staff, and visiting the public housing associations in the area.

- Over 1,300 (duplicated counts) adults and youth attended the nine physical activity classes offered during the Fall 2005 program. Class attendance continues to grow.

- With additional funding, HHI will make physical activity classes available in other communities that are lacking adequate facilities and opportunities for physical activity.

Walkable Communities/Safe Routes to School

This project is designed to create safer environments and opportunities for physical activity for school-age children. Communities and schools work together to develop accessible environments for walking.

- A successful program will improve the health and safety of students and residents of the neighborhoods that live near schools.

- Traffic will be reduced around schools, and students will be more physically active, potentially improving alertness, behavior, and reducing barriers to learning.

III. Public and Professional Education

HHI's public education campaigns are designed to increase knowledge, change attitudes, and provide solutions to barriers for nutrition, physical activity, and tobacco cessation through mass media and community events. The combined public education and social marketing campaign for HHI is based on a socio-ecological model to effect behavior change at multiple levels of society (individual, interpersonal, organizational, community, and societal). This model not only addresses individual level knowledge, attitudes, and self-efficacy related to behavioral change, but also the social supports, policies and environmental barriers and facilitators to such behavioral change. The overall strategy was to create a comprehensive, multi-faceted social marketing campaign targeting the public at large, in order to increase awareness of approaches to healthier lifestyles.

Funding reallocations reduced public education efforts and ended the comprehensive media campaign contract with Starr Seigel. The tobacco prevention media budget was not reduced, so as not to lose the momentum of an effective social marketing campaign, as shown through the continued decline in youth and adult smoking rates in Hawaii. In moving forward, HHI will develop request for proposals for specific media messages that target attitude and behavior change identified through data collected by the DOH. These messages will also be integrated with community, school and professional education initiatives. This model stretches resources by keeping coordination of the social marketing campaign in-house. Also, the targeted messages can be produced and broadcast more efficiently, thus increasing the ability to provide more public health education.

The "1% or Less is Best" Milk Campaign

Saturated fat is linked to high incidences of heart disease. A major source of saturated fat is whole and 2% milk. In 2004, HHI launched the "1% or Less is Best" milk campaign, a statewide intervention that educated the public on the high fat content of whole and 2% milk and encouraged residents to switch to low-fat milk (1% and skim). By tracking milk sales, HHI found approximately 60,000 adults switched to low-fat milk during the course of the campaign. On October 10, 2005, HHI re-launched a six-week milk campaign to reinforce and encourage the healthy choice.

- The nutrition education campaign included media and public relations activities such as tv and radio commercials, tv and radio interviews, web-based contests, and PSA posters on all city buses.

- Many people hesitate to drink 1% or less because they think they do not like the taste. Taste Test Challenges are blind taste tests, where challengers are asked to sample and correctly identify four kinds of milk (whole, 2%, 1% and skim). In addition they are asked if they like the taste of the milk. 99% of the participants reported they liked the taste of 1% and skim milk. The Taste Test Challenges have been an extremely effective interactive tool that help people overcome the hesitation to drink low fat milk.

- Taste Test Challenges were conducted at Jarrett Middle School and Kid's Fest at the Bishop Museum, where approximately 1,000 families attended.

- The Taste Test Challenges and "1% or Less is Best" message were featured in news stories on KHON2, KITV4 and the Star Bulletin.

Tobacco Prevention & Education Program Counter-Marketing

Counter-marketing activities have been shown to promote smoking cessation and to decrease the likelihood of youth smoking initiation. Over the past six years, the Hawaii Tobacco Prevention & Education Program (TPEP) has developed a highly successful, award-winning and well recognized statewide media initiative through use of HHI funds. HHI funds also support the state's ongoing youth tobacco surveillance effort by funding the Hawaii Youth Tobacco Survey (2000, 2003 and 2005).

- A recent report by the CDC revealed that Hawaii youth (aged 12-17) see an average of 0.9 state-funded anti-tobacco television ads per month, thus ranking 17th among the 37 major media markets (*MMWR* 2005, 54(42): 1077-80.)

- Independent evaluation of the statewide youth media campaign demonstrated that over the past three years 9 out of 10 youth surveyed (ages 11-17) were aware of the DOH/TPEP ads.

- The 2003 Hawaii Youth Tobacco Survey (YTS) revealed that 72% of middle school and 80% of high school students in public schools have seen or heard at least one anti-tobacco advertisement on the television, Internet or radio in the past month; moreover, 2 out of 5 have seen or heard anti-tobacco advertisements daily within the past month.

- Between 2000 and 2003, current cigarette smoking among Hawaii students decreased 60% in middle school and almost 40% in high school to 5% and 15%, respectively. (YTS)

- Between 2000 and 2004, Hawaii adult cigarette smoking prevalence decreased 15% to 17%. (Behavioral Risk Factor Surveillance System)

Professional Education Contract

In a recent survey, almost 50% of respondents stated if their physician recommended that they walk 30 minutes a day, it would be extremely likely they would follow this advice. With the reallocation of funding, HHI did not re-fund the professional education contract in fiscal year 2005. HHI is negotiating a contract for fiscal year 2006 to standardize the integration of the discussion of physical activity and nutrition related questions and recommendations into physician's patient screening. Deliverables will include physician training, tool kits for physicians and easy to understand informational brochures for patients. In response to the concern of childhood overweight, the pediatric residents and physician group will be the target of the professional education project.

IV. Surveillance, Assessment, Evaluation, and Research

The Informatics Project and the Hawaii Health Data Warehouse

Through the HHI Informatics Project, the Hawaii Health Data Warehouse (HHDW) was created in a partnership with the University of Hawaii John A. Burns School of Medicine (JABSOM). The overarching goal in the partnership was to provide surveillance and evaluation for public health in Hawaii. The HHDW was built as a supporting tool that is a neutral, credible source to process, integrate, analyze and share information with communities, agencies, potential funders, legislators, and other stakeholders to support informed decision-making about the health and welfare of Hawaii's people. The Informatics Project provides departmental technical training in order to improve the collection, use and presentation of data, and to increase the utilization of the HHDW.

The Informatics Project has made significant contributions in two important areas:

1. The Data Management Training

- HHI funding was used for data management training to increase the capacity of the DOH staff to use data for program planning and evaluation.

    - Training was provided in a collaborative, multi-disciplinary manner, incorporating the most advanced educational and technological developments. This enabled DOH public health workers and professionals to solve problems using contemporary skills, and to mentor and share these newly learned skills.

    - The Informatics Project launched seven new data management-training modules that build on the original six courses from year 2004.

    - Seven training modules were successfully developed and delivered: (1) Exploring Public Health Information Using the World Wide Web; (2) Hawaii Survey Data; (3) Using Epi Info (including a GIS session); (4) Writing for Public Health (including private consultation session); (5) Transforming Raw Public Health Data into Useful Products; (6) Reading and

Interpreting Public Health Publications; and, (7) Hawaii Health Data Warehouse Training (select participants only).

- Instructors from John Hopkins School of Medicine, JABSOM, and CDC taught six of the seven modules for a total 162 hours of classroom instructions or 23 training sessions.

- The training was attended by 113 participants. Thirty-five percent attended three or more of the modules.

- DOH participants represented a range of job categories, including but not limited to, planners, epidemiological specialists, researchers, biostatisticians, health educators, administrators, registered nurses, and public health analysts.

- Non-classroom based training is available and includes a combination of self-directed or team-learning using videos, workbooks, audiotapes, Web-based instruction with e-mail support, web casting, and mentoring/coaching using DOH, UH, and other community resources.

2. Hawaii Health Data Warehouse (HHDW)

- In order to develop Hawaii's public health infrastructure, the Informatics Project developed the HHDW as a database of the public health data required to produce community health indicators in support of surveillance activities and research.

    - HHDW contains data from eleven DOH public health datasets, which include 110 community indicators. The information is available over the internet and uses standard commercial products for statistical analysis and reporting.

    - Specific reports can be produced based on parameters set by users. Reports display information about health status, risk factors and health resources. Local (community level) measures can be compared with county, state, and national benchmarks. Where data allow, all indicators are stratified by key demographic and socioeconomic dimensions.

    - The DOH and community health agencies use the HHDW to access health information, monitor and assess disease trends, provide information for community and program planning, identify issues needing public health research, guide prevention and intervention programs, and to monitor population-based health status improvement.

Science and Research Group (SRG)

To increase the competencies of DOH public health professional staff to utilize the data warehouse and to align practice and policy, the Science and Research Group (SRG) is being established on a complementary track with the HHDW.

- The SRG will be responsible for further assessment of staff competencies, determining current data tools, practices and policies. The assessment will help identify needs for optimizing data collection, analysis, and sharing. These changes will allow the DOH to assess the health status of the people of Hawaii more efficiently. The information will be used by HHI and other programs to adjust health promotion and chronic disease prevention strategies.

- The SRG will establish policies and training around data collection and usage.

Social Epidemiology Project

In conjunction with the HOI, this project coordinates and supports the development and implementation of epidemiological research related to planning and evaluating public health interventions to promote healthy lifestyles among the general population of Hawaii. Objectives include designing behavioral interventions to reduce risk factors of chronic diseases, calculating standardized and adjusted rates, and conducting survey research. The Social Epidemiology project also provides technical guidance to and evaluation of the Healthy Hawaii Initiative.

- The Social Epidemiology Project has helped in rebuilding the University of Hawaii School of Public Health. The project investigator is the Graduate Chair of the department and has developed a Master's in Public Health degree and Master's in Science in Social and Behavioral Health Sciences.

- 15 students enrolled or have graduated from this nationally accredited program. This training meets a critical need for Hawaii's workforce. Future plans include the development of a Ph.D. program and expanding the training program to include environmental health, health policy and administration and biostatistics.

- Over the past four years, eight fellows have been trained as part of the evaluation team. These individuals are positioned to take leadership roles in program evaluation in the future.

Surveillance

HHI supports the Hawaii School Health Surveys (HSHC) in conjunction with the DOE with funding from the CDC cooperative agreement to support the Coordinated School Health Program. CDC and HHI funds are used to administer the Youth Risk Behavioral Survey, while HHI solely funds the Youth Tobacco Survey. Planning, administration, and reporting of the school surveys are coordinated through an interagency group, the HSHS Committee. HHI also provides some funds to add items to or increase the sampling size for the Behavioral Risk Factors Surveillance Study, the CDC study of adult behaviors conducted through the Department of Health.

Tobacco Retailer Inspections

HHI funds the tobacco retailer inspections for enforcement of the tobacco control law prohibiting sales to minors through the Alcohol and Drug Abuse Division.

- Retailer violation rate 5.6% (weighted) in 2005; was 44.5% in 1996.

- Hawaii's violation rate is the fourth-lowest in the nation, behind Delaware, Mississippi and Iowa.

Attachment 1:

Professional Assessment of HHI

In December 2004, Dr. James F. Sallis, Director of the Active Living Research Group (of the Robert Wood Johnson Foundation), conducted an assessment of HHI.

Dr. James Sallis is Professor of Psychology at San Diego State University and the Program Director of Active Living Research. Dr. Sallis is a nationally, and internationally, recognized authority on physical activity interventions and behavioral research. He has made major contributions in the areas of measurement, identifying correlates of physical activity, intervention and advocacy. He has extensive experience with measurement development, interventions, ethnically diverse populations, school programs, adolescent health and project management. Dr. Sallis has worked with multiple community agencies and has written about community youth physical activity promotion.

He is a frequent consultant to government agencies, research programs, health organizations and corporations throughout the United States and internationally. He served on the editorial committee for the 1996 U.S. Surgeon General's Report Physical Activity and Health and is on the editorial boards of several journals. Dr. Sallis has authored over 250 scientific publications, is co-author of Physical Activity and Behavioral Medicine (Sage, 1999) and a health psychology textbook, Health and Human Behavior (McGraw-Hill, 1993).

Active Living Research Group

Sponsored by The Robert Wood Johnson Foundation, Active Living Research is a leading organization researching and examining relationships among characteristics of natural and built environments, public and private policies, and personal levels of physical activity. Active Research supports the translation of scientific research for use by policy makers and serves as a resource for researchers and policy makers

Active Living Research has three primary objectives:

- To establish a strong research base regarding the environmental and policy correlates of physical activity.
- To help build a transdisciplinary field of physical activity policy and environmental researchers.
- To facilitate the use of research to support policy change.

December 29, 2004

To: Susan Jackson and the Healthy Hawaii Team

From: James F. Sallis, Ph.D.
Director, Active Living Research

Re: Assessment of the Healthy Hawaii Initiative (HHI)

Assessment of Progress

There is much to be pleased with regarding the progress of HHI. The foresight and good judgment of state officials in devoting a substantial portion of the Tobacco Settlement funds to improving the health of Hawaiian population is commendable. However, constant vigilance is required to maintain adequate funding of HHI, as shown by the recent reduction in funding. Because HHI targets the three leading causes of death and disability (tobacco use, physical inactivity, poor diet), efforts to divert legislated resources should be seen as threatening the health of the population. HHI staff are fighting valiantly to maintain funding, but more allies and champions among the state's politicians are needed.

The overall goals of the program are exemplary—to increase quantity and quality of life and to reduce health disparities. The organization also is outstanding. The leadership team is strong, and the productive partnership with the University of Hawaii has produced tangible benefits. The approach of working at multiple levels to change people, environments, and policies reflects the best current thinking in the field. Even though it is not easy to work on all these levels at once, and the efforts to date have included successes and failures, HHI is a model for other states. It takes years of well-planned extensive efforts to change behaviors of a population, so perseverance and incremental advancement are required. There are already signs of progress with the favorable statewide trends in overweight and physical activity, but those early signs only mean the program is going in the right direction, not that the goals have been achieved. The surveillance and evaluation functions are exceptionally well designed and implemented, and they provide information that can be used to improve all components of HHI.

The three program components of school intervention, community change, and public and professional education are all worth keeping and refining. The experience of the past few years provides guidance for how to improve each component. My assessment of each component is summarized in the next section, integrated with recommendations for enhancements

Recommendations for the Next Five Years

<u>School Interventions</u>
Youth is when people start to smoke, physical activity declines dramatically, and poor dietary habits are established. In addition, there is a well-documented childhood obesity epidemic. Thus, there is a strong rationale for the school component to target youth. The HHI team is to be congratulated for focusing on making policy and environmental changes at schools and in working with complexes of feeder schools. This kind of comprehensive approach is needed for large and long-term changes. The policies adopted to date are a mix of small (directory of resources) and large (expanding after school activities), so in the future the emphasis needs to shift to achieving more of the larger policy changes. HHI can take several steps to improve the ability of school policy groups to make major changes, and I recommend you consider the following:

- be more involved in identifying and recruiting leaders of school policy change groups
- provide modest compensation for leaders
- provide ongoing technical assistance so you can identify changing needs of policy groups and meet those needs
- work more directly with school principals, perhaps by getting on the agendas of principal conferences on a regular basis
- expand the effort to recruit more school complexes

The ongoing collaboration between the Departments of Health and Education is promising. Changing policy in the statewide school district will have widespread effects, especially if HHI can support full implementation of new healthful policies in all schools. On the other hand, it takes longer and is more difficult to realize changes in a centralized agency. Working with principals can be a means of affecting statewide policy. I recommend using principles of innovation diffusion whereby you find principals who are opinion leaders in general, recruit them to become leaders of health policy change, then expand the network of advocates who support the changes. When many principals already support the policies, it may be easier for the state to make changes. A combined top-down and bottom-up approach could be effective.

Substantial resources have been devoted to standards-based workshops for physical education (PE) and health education. I question the wisdom of this focus. The standards approach is not the only one, and it may not be compatible with the desired outcomes of HHI. I recommend workshops that train teachers to use evidence-based PE and health education curricula that are compatible with standards. The PE standards are likely to call for a great deal of transfer of knowledge, whereas evidence-based programs such as SPARK and CATCH have been shown to make PE classes more active. Health education standards are likely to have many knowledge-based objectives, and we know improving knowledge is not sufficient to change behavior. I recommend identifying health education curricula that have evidence of promoting behavior change. Precious workshop time should be used for teaching teachers to use evidence-based PE and health education curricula.

Teachers are expert at implementing classroom curricula. However, the classroom teachers who are usually responsible for teaching PE in elementary schools are much less prepared for this different kind of teaching. As you transition to teaching more evidence-based PE, it is essential that you provide elementary school teachers with ongoing support. Identifying a PE facilitator at each school is necessary, because this person handles the logistics of scheduling and managing equipment. It would be useful to have a group of trained PE consultants who visit elementary schools periodically to observe teaching of PE, provide helpful feedback and assistance, and offer some ongoing training.

Community Interventions

Funding community groups to advocate for policy and environmental change is an excellent approach because it builds capacity that stays in communities, and several examples of success have been identified. I was impressed that the HHI team has taken steps to remedy some deficiencies of the specific programs. I agree with the plan to fund fewer groups on each island so each community group is better prepared to advocate for island-wide changes. There may be value in funding some groups that target specific populations such as older adults or youth, so some islands could have more than one coalition. Having fewer groups will allow more adequate funding of each group. Similar to the recommendations for school policy groups, I recommend more attention paid to selection, training, and technical assistance. HHI can consider doing the following:

- be more involved in identifying leaders and members of community groups
- provide ongoing training in advocacy skills
- teach community groups about evidence-based community programs
- provide ongoing technical assistance so you can identify changing needs of policy groups and meet those needs
- reserve part of the funding for competitive grants, so proposed community projects can be reviewed regarding their likelihood of contributing to behavior change

Keep the community groups focused on environmental and policy change. There seems to have been an overemphasis on programs and activities like health fairs that are costly but have little chance of affecting behavior. Health fairs can contribute to program visibility, but community groups can achieve recognition by making more lasting impressions. For example, they could erect signs that point out walking or biking paths, tell how many steps to a nearby destination, or simply promote physical activity. Placing the group's and HHI's logos on the signs makes for a permanent presence and cue for behavior. When the group succeeds in getting sidewalks or bike paths built, put the group's and HHI's logos on them. If involvement in health fairs continues, then the groups should be required to include an advocacy component, such as having petitions to sign or writing letters on the spot to their local representatives. The tobacco coalitions seem to

be more focused on long-term change, so they can be a model for the diet and physical activity community coalitions.

Public Education

Because Hawaii is a small media market, it is feasible to have a public education campaign with substantial paid media. Thus, this is a realistic intervention component and should be continued. However, the media component should be more closely integrated with other program components. It was important to start with program awareness and that has been very successful. A next phase to make sure people are aware of the practical physical activity and nutrition guidelines is also important. I envision two additional goals to be achieved over the next five years.

The first goal is to teach effective behavior change strategies that are needed to change the behaviors. Multiple skills need to be targeted, and different ads are needed for various subgroups, so this phase should last several years. These media messages should be built upon ongoing population surveys that identify skills that are lacking in the Hawaiian population.

The second goal, which should overlap in time with skills development, is to promote citizen involvement in policy changes. It is essential to identify policies that can be expected to lead to behavior change and that are supported by a majority of the population. These can differ by island, and there should be coordination between policy-related media messages and the policy goals of community coalitions. This is the kind of multi-level intervention that should be most effective. The media messages may need to inform people about the promise of the policies, their level of support, and ways that each person can advocate for the policy. Of course, all these cannot be done in the same ad. Policy advocacy should be seen as a multi-year media strategy.

Professional Education

Health professionals have a duty to contribute to solving the problems of inactive lifestyles, poor diets, and smoking. However, there are severe limitations to what they can contribute, so expectations should be realistic and investments should be proportionate to likely results. The key limitations are that health professionals have limited training in effective behavior change methods, limited time to devote to counseling, and in many cases, limited interest. The brief educational sessions that were funded previously do not seem worthy of continuing.

The most fruitful approach would be to find evidence-based approaches or at least existing materials that could be adopted. Examples include AMA's Guidelines for Adolescent Preventive Services (GAPS), Bright Futures from DHHS, PACE, the Green Prescription from New Zealand, and NHLBI's ACT. GAPS and Bright Futures are specifically designed for youth. One caution is that effects of counseling from health care providers are usually found to be modest, though the impact on the whole population can be important. Other goals could include screening, charting, and feedback on BMI. Outstanding physician and nurse educators should be recruited to develop CME programs for the selected programs that could be offered regularly. You could work with directors of residency programs, community clinics, and military facilities to adopt programs and training. These types of more extensive trainings should be much more effective at changing practice than brief lectures. Ideally, HHI could pay for professionals to follow-up with those who have been trained to help them overcome barriers to implementing the programs.

Surveillance and Evaluation

The evaluation of HHI is also a national model. Among its strengths are use of a variety of methods, including surveys, direct observations, and key informant interviews. Presentations of results at national scientific conferences create excellent visibility for HHI as well as opportunities for input from interested experts. At the same time, evaluation provides practical feedback that is needed to refine the various approaches. Without ongoing feedback, it is impossible to know which approaches are effective and how well the funds are being spent. The emphasis on quality evaluation should be maintained, but improvements can be made. Public support for key policies needs to be assessed periodically. Training and technical assistance needs of selected stakeholder groups like coalitions, school administrators, health professionals, and local government officials need to be assessed so interventions can be adjusted to meet changing needs. Personally I would like to see HHI develop a list of key policy and environmental indicators of success, then systematically assess those indicators on all islands on a regular basis. This would be a useful extension of current evaluation activities.

Recap of Key Themes

- Devote more attention to building expertise in policy change groups in schools and communities. This may require additional staff that can provide technical assistance.
- Identify and develop leaders who can be champions in each community.
- Place more emphasis on implementing evidence-based approaches that have been shown to actually change behavior. The National Cancer Institute's "Cancer Control Planet" website evaluates many programs and is a good place to start. DASH-CDC and The Robert Wood Johnson Foundation are both working on similar resources.
- Create more tie-ins across the intervention components, such as using mass media to promote the same policy changes that are targeted by community coalitions or school policy change groups.
- For all intervention components, move from awareness and knowledge goals to behavior change skills and policy advocacy.
- Continue to use evaluation results as feedback to refine program goals and methods.
- Expand evaluation efforts to track selected policies and environmental indicators on each island.

Disclosure: I am a co-creator and have a financial interest in SPARK and PACE.

Attachment 2:

The Healthy Hawaii Initiative: Goals and Objectives

Vision: Healthy Communities, Healthy People, Healthy Island

Mission: Ensure that people in Hawaii have healthy beginnings in early childhood, healthy growth and development through childhood, and healthy adult lifestyles based on good nutrition, regular physical activity, and freedom from tobacco use.

Goal: Increase years of healthy life for all and reduce existing health disparities among ethnic groups in Hawaii.

Health Status Objectives	Risk and Protective Factor Objectives
1. By 2020, reduce coronary heart disease deaths to no more than 166 per 100,000 in all populations. 2. By 2020, reduce stroke deaths to no more than 48 per 100,000 in all populations. 3. By 2020, reduce the incidence of Type 2 diabetes to no more than 2.5 per 1,000 in all populations.	1. By 2010, decrease the proportion of adults who are overweight or obese to no more than 40%. 2. By 2010, reduce the proportion of children and adolescents who are overweight or obese to 15%. 3. By 2010, increase the proportion of persons aged 2 years and older who consume at least three servings of vegetables. 4. By 2010, increase the proportion of persons aged 2 years and older who consume at least two daily servings of fruit to 75%. 5. By 2010, increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes each day to 30%. 6. By 2010, reduce the proportion of adults who engage in no leisure-time physical activity to 20%. 7. By 2010, increase the proportion of youth who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes each day to 50%. 8. By 2010, decrease the prevalence of smoking among adults to less than 15%. 9. By 2010, decrease the prevalence of smoking among high school students to less than 20%.

Short Term Outcomes

- By 2008, tobacco sales rates to minors will maintain to no more than 10%.
- By 2008, 60% of secondary health education and physical education and 25% of elementary school teachers will have participated in professional development in HE and PE.
- By 2006, a recognition program to acknowledge schools that reach standards for healthy schools will be developed.
- By 2008, 20% of schools statewide will reach the criteria set by the healthy schools recognition program.
- By 2006, a comprehensive media campaign consistent with HP 2010 objectives will be developed and implemented.
- By 2008, 80% of the population will recognize the media campaign.
- By 2008, reduce the percentage of adults in pre-contemplation for adequate physical activity to no more than 15%.
- By 2008, reduce the percentage of adults in pre-contemplation for eating five fruits and vegetables a day to no more than 25%.
- By 2006, the state physical activity and nutrition plan will be developed and in implementation.
- By 2008, state buildings will have an increase in healthy vending options in cafeterias.
- By 2008, 75% of pediatric and family practice medical residents currently enrolled will be trained in nutrition and physical activity curriculum.